TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Trenton D. Weeks, DC

Respondent Name
Ascension Health

MFDR Tracking Number
M4-15-1704-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 9, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…I performed an evaluation to determine maximum medical improvement and impairment of the … claimant. I performed this examination at the request of the injured employee and the treating doctor.

03/13/2014 Carrier EOR indicates code:

- (218) Based on entitlement to benefits

… This examination was performed for the purpose of determining MMI and Impairment as it related to the work injury… This evaluation addresses compensable body part(s) and not specific diagnosis... All reports from health care providers as well as the injured employee state injury to the neck and upper back. This is a medical maximum improvement examination which is only relative to the musculoskeletal area/part…

05/07/2014 Carrier EOR indicates code:

- Payment remains denied. MMI was certified per the DDE completed on 04/13/2010. Additional exam unnecessarily completed.

…The DD Exam on 04/13/2010, placing the claimant at MMI was premature as the injured employee was not ripe for MMI. The injured employee had not exhausted ODG recommended treatment for her injury at that time and was still participating in conservative treatment plan… Neurosurgical evaluation dated 06/03/2010 states disagreement with previous MMI as the injured employee still had continued symptoms relating to the work injury. The injured employee's persistent pain and symptoms were successfully treated by injection and provided 6 months of relief demonstrating improvement subsequent previous DDE …"

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on February 18, 2015. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The

insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 11, 2014	Examination to Determine MMI/IR by Referral Doctor	$500.00	$500.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.240 sets out the procedures for paying or denying medical bills.
3. 28 Texas Administrative Code §134.204 sets out the guidelines for billing and reimbursing Division-specific services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 218 – Based on entitlement to benefits
   - OA – The amount adjusted is due to bundling or unbundling of services.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the correct Maximum Allowable Reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied the disputed services with claim adjustment reason code 218 – "Based on entitlement to benefits." 28 Texas Administrative Code §133.240 (h) requires that "An insurance carrier shall have filed, or shall concurrently file, the applicable notice required by Labor Code §409.021, and §124.2 and §124.3 of this title (relating to Investigation of an Injury and Notice of Denial/Dispute) if the insurance carrier reduces or denies payment for health care provided based solely on the insurance carrier's belief that: (1) the injury is not compensable; (2) the insurance carrier is not liable for the injury due to lack of insurance coverage; or (3) the condition for which the health care was provided was not related to the compensable injury." Review of the submitted information finds that the insurance carrier did not support a denial based on entitlement to benefits in accordance with 28 Texas Administrative Code §133.240 (h).

   The insurance carrier also denied the disputed services with claim adjustment reason code OA – "The amount adjusted is due to bundling or unbundling of services." 28 Texas Administrative Code §134.204 sets out the guidelines for billing and reimbursing Division-specific services. A review of these fee guidelines does not find that the disputed services are bundled.

   The insurance carrier's denial reasons are not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. Per 28 Texas Administrative Code §134.204 (j)(3), "The following applies for billing and reimbursement of an MMI evaluation… (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation indicates that the requestor performed an evaluation of Maximum Medical Improvement. Therefore, the correct MAR for this examination is $350.00.

   Per 28 Texas Administrative Code §134.204 (j)(4), "The following applies for billing and reimbursement of an IR evaluation… (C)(ii) The MAR for musculoskeletal body areas shall be as follows. (I) $150 for each body area

if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used." The submitted documentation indicates that the requestor performed an evaluation to determine the impairment rating of the spine using the DRE method found in the AMA Guides 4th edition. Therefore, the correct MAR for this examination is $150.00.

3. The total allowable for the disputed services is $500.00. The insurance carrier paid $0.00. Therefore, an additional reimbursement of $500.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $500.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $500.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	May 29, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.